AARP is a 35 million member nongovernmental organization representing and addressing the needs and interests of persons over age 50. We lead positive social change and enhance the quality of life for people over 50 through social policy, group buying arrangements, communications, advocacy, and community service.

Through the AARP Global Aging Program, we facilitate understanding and dialogue around the global aging agenda by convening and participating in international social and economic policy debates worldwide. Working with governmental and nongovernmental organizations to exchange ideas and establish “best practices” in addressing aging concerns worldwide, the AARP Global Aging Program is currently focused on the issues of pensions, labor markets, age discrimination, health care, long-term care, and advocacy.
Executive Summary
AARP International Forum on Long-Term Care

As a part of its Global Aging Program, AARP held a half-day forum on October 22, 2003 that examined how several European countries, Australia, New Zealand, and Japan have developed and/or reformed their policies with respect to long-term care. The primary goal was to understand the lessons that these countries’ experiences might offer for the United States.

Introduction
William D. Novelli, AARP’s Chief Executive Officer, emphasized how much different countries have to learn from each other on issues related to aging, noting that most countries are wrestling with similar issues, albeit in somewhat different ways and from different points on the aging curve. Policies are needed to address one of the biggest issues facing most if not all countries — how to finance long-term care. But there are also other issues. Consumers want long-term independence, not long-term care. They also want options and choices, and they fear losing independence and control. Public policy decision-makers fear the mounting costs of public reimbursement programs, while providers fear that tightening reimbursement will make it impossible to meet the growing demands for higher quality services. These mutual fears and distrust threaten a downward spiral of budget cuts, quality problems, and litigation. To address these fears, governments need to look beyond the immediate budget crunch and make systemic changes to promote consumer choice and enhance the quality of services.

The Challenge of Long-Term Care: A Search for Solutions
Joanne Disch, Ph.D., R.N., F.A.A.N., AARP Board Member, and Professor and Director of the Katharine J. Densford International Center for Nursing Leadership at the University of Minnesota, reviewed international approaches to the financing and delivery of long-term care. Like Mr. Novelli, Dr. Disch emphasized that the needs of older people can and should be met in an environment of their choice, which surveys suggest is usually the home (as long as there is easy access to community-based services). Even so, some individuals still need to receive services in assisted living facilities such as residential care apartment complexes. But regardless of the setting, the key challenge facing countries is to create a situation where people
receive quality care that is accessible and affordable to all who need it.

Different countries have tried to meet this challenge in different ways. Many are trying to introduce the concept of consumer-directed home care, which gives individuals, rather than agencies, control over the provision and delivery of home health services. Individual states within the U.S. are also beginning to get the message, and as a result the number of consumer-directed programs is growing. A 2001 survey conducted by the U.S. General Accounting Office shows that only two states do not offer at least one consumer-directed program. Dr. Disch highlighted a few examples of innovative programs in Indiana and Wisconsin (see full proceedings for details).

The 2004 Long-Term Care Study: Preliminary Findings
Jeremy Hurst, head of the Health Policy Unit of the Organization for Economic Cooperation and Development (OECD), reviewed the preliminary findings from the long-term care portion of the OECD's Health Project (2001-2003), which is based on a review of 18 countries. Key findings related to expenditures on long-term care include the following: some countries spend up to 2.5 percent of their GDP on long-term care, although most spend less; institutional care still dominates spending, with private spending even more concentrated in institutional care; expenditures on long-term care are concentrated on the very old; the government’s share of total funding for long-term care has increased significantly in some countries with new social insurance schemes, while growth has been slower in other countries; out-of-pocket expenditures for long-term care are much higher than for acute health care in most OECD countries; private long-term care insurance is growing in some countries, albeit from a very low base; and increases in expenditures are currently being driven more by policies to expand services than by the aging of the population.

The study will also examine policy issues and trends related to consumer-directed care. Key findings include the following: there is a trend toward more choice and participation for users of long-term care services; support for home- and community-based care as an alternative to institutional care is growing; policies to sustain the efforts of informal caregivers are gaining in popularity; consumers are increasingly being given the choice between having agencies hire and direct their care assistants and being allowed to do this on their own; competition and the growth of local “markets” for home care is increasingly being seen as a way to improve quality
and cost-efficiency; and countries differ in the way that consumer-directed care programs are organized.

A third part of the long-term care study will attempt to project future expenditures based on a variety of assumptions. One analysis concluded that the proportion of GDP spent by governments on long-term care will double between 2000 and 2050.

Lessons from Abroad: International Approaches to Long-Term Care

The forum included a panel in which four experts described the approaches to long-term care that are being taken by other countries, drawing out potential lessons for the U.S. John Rother, Director of Policy and Strategy at AARP, moderated the session.

The German Experience

Franz Knieps, Director General for Health Care, Health Insurance, and Nursing Services at the Federal Ministry for Health and Social Security in Germany, described the German system for long-term care. Germany’s long-term care system is financed primarily through public funds raised through income taxes paid by individuals and employers. Roughly 90 percent of Germans are enrolled in the public system; the remaining 10 percent, composed primarily of the wealthy, “opt out,” instead purchasing mandatory private health and long-term care insurance.

Germany recently enacted a series of reforms with respect to long-term care. The reforms have met their goal of reducing dependency on institutional care—before they were enacted, 80 percent of those needing long-term care were served in institutional settings, while today that figure is only 25 percent. The first step in the German reforms was to establish a minimum home care benefit for all Germans in the public system. The second step was to allow those who receive care from family members or other acquaintances to opt out of the agency-based system, and to instead pay the caregiver directly for providing these services. The third step in the German reforms was to redefine the institutional benefit so that it became equal to the benefit for home health services. The final step was to enact safeguards to better ensure the quality of services in nursing homes, including bolstering the rights of residents of these homes.

Germany plans to continue reforming and improving the long-term care system. One of the key challenges facing the system is how to strengthen support and care for patients with dementia and their family members. Another challenge relates to controlling overall costs of long-term care.
The Dutch Experience

P. J. van de Kasteele, Deputy Director of the Department of Residential and Domiciliary Care and Seniors’ Policy at the Ministry of Health, Welfare, and Sports in The Netherlands, offered an overview of the Dutch system for long-term care. The economic boom of the 1960s encouraged the Dutch government to enact a broad social insurance scheme for the whole population, one that originally covered only nursing home care. But over time the benefits expanded to include home nursing care in the 1970s, home care in the 1990s, and residential home care as of 2001. Today the system covers the entire population and is financed through a premium assessed on the basis of taxable income and administratively raised by government tax authorities. Total projected costs are $13 billion annually, equivalent to 2.7 percent of the Dutch GDP. The long-term care benefit is administered by health insurance companies that contract with the providers of services. The Netherlands has a substantial provider network set up to provide long-term care services. The Ministry of Education is responsible for vocational and professional schooling of those interested in careers in long-term care, and for training of staff in facilities. A division of the Ministry of Health projects the need for different types of medical specialists and works with the Ministry of Education to plan for schooling. Long-term care providers are not required to use any particular type of staff mix, but they are required to have a quality assurance plan. Anyone who wants to build a new facility must receive approval from the Ministry of Health.

The biggest problem facing the Dutch system is that patients do not pay their own bills, meaning that no one outside the government has much of an interest in cost control. This problem will become worse over the next 40 years, as the number of people age 75 and over is expected to double during this period. The government has made attempts to control costs in the past, primarily by limiting the building of new facilities. As a result, there are waiting lists for services.

The focus of the Dutch government going forward will be to emphasize home-based care rather than institutional care. The government is also beginning to rethink its financing of comprehensive benefits for the entire population. In addition, the government is looking for ways to introduce regulated market conditions into the delivery of care, so as to create an economic incentive for insurers, providers, and patients to improve the efficiency of the system.
Consumer-Directed Home Care in The Netherlands, England, and Germany
Joshua M. Wiener, Ph.D., RTI Fellow and Program Director of Aging, Disability, and Long-Term Care for RTI International, reviewed the results of a study (commissioned by AARP’s Public Policy Institute) comparing consumer-directed home care in the Netherlands, England, and Germany. The development of publicly funded, consumer-directed home care programs represents a major innovation in the delivery of long-term care services. These programs give consumers, rather than home care agencies, control over who provides services, when they are provided, and how services are delivered.

- All three countries offer a choice of consumer- or agency-directed home care, using various systems for determining the size and administration of the consumer-directed benefit. In the Netherlands and England, any money paid must be spent on services, while in Germany there are no such restrictions. In the Netherlands and Germany, money can be paid to support informal caregivers, such as family members.

- The number of beneficiaries who choose consumer-directed care varies across countries and patient characteristics. In the Netherlands roughly one in 10 of those receiving home care services has opted for consumer-directed home care, while in England the comparable figure is only about two percent. In Germany, 75 percent opt for the cash payment.

- The role of informal caregivers also varies. In the Netherlands and Germany informal caregivers are supported, while England excludes close relatives from the system.

- Each country views the programs as a way to contain costs compared to agency-based care.

- Each country lacks traditional quality assurance mechanisms. While all three have minimal external review, oversight is not nearly as stringent as for agency-directed care. Instead, these programs rely on the consumer, competition across providers, and family members to ensure the provision of high-quality services.

The Japanese Experience
John Creighton Campbell, Ph.D., Professor of Political Science at the University of Michigan and an expert on social policy in Japan, reviewed Japan’s startling innovation in long-term care policy. The Japanese system is a public, mandatory, social insurance system in which all individuals over the age of 40 pay premiums based on income, and all those aged 65 and over are eligible for services, with eligibility deter-
mined by an activities of daily living (ADL) test. Neither income nor the availability of family care is taken into account. General tax revenues finance roughly half of the system, with the remainder coming from the premiums paid by workers and seniors themselves. Approximately 3.5 million individuals—equivalent to 14 percent of the 65-and-over population—have been certified as in need of services. Total costs are equal to about $30 billion a year in purchasing-power-parity dollars. By 2010, that figure is expected to rise to $70 billion, or 1.5 percent of GDP.

The current Japanese system is the product of reforms that began in 1990. After starting down the "road to Scandinavia" in 1990 with a major expansion of direct services for frail seniors, the government and the Liberal Democratic Party looked instead toward Germany. They came to see the advantages of a social insurance system financed largely through earmarked premiums, with delivery via individual entitlement and consumer choice, rather than tax-financed monopoly provision. The long-term care insurance scheme was passed in 1997 and implemented in 2000. The Japanese program has worked well thus far; 2.5 million Japanese citizens were certified for eligibility in the first year and the program has grown rapidly, by 45 percent over three years in terms of both funding and the number of people served.

The Japanese experience demonstrates that providing access to comprehensive long-term care is feasible and does not entail the same level of financial risk associated with medical care. Moreover, paying for services only (as opposed to also offering a smaller cash benefit, as in Germany) can actually result in cost savings.

Reforms and Best Practices in Australia and New Zealand
The final two presentations focused on the reform experiences of Australia and New Zealand.

The Australian Experience
Philip Davies, Deputy Secretary of the Department of Health and Ageing in Australia, provided an overview of Australia’s reform process. Over the past twenty years, the Australian long-term care system has undergone significant change. In the mid-1980s, the Australian Government introduced a service provision benchmark for residential care. In October 1997, the Australian Government introduced a structural reform package to produce a more seamless and sustainable system of long-term care delivery. A recent two-year review found that the reform package had improved access to care. In recent years, the Australian Government has substantially
expanded the number of non-
residential care options, has pro-
vided a number of older people
with high-level care, and has
substantially increased funding
for programs to assist caregivers.
A March 2003 paper broadly
outlined additional proposed
reforms, including aligning
services with levels of need,
developing a common access
framework, reducing duplication
in assessment and data collect-
tion, and streamlining adminis-
trative and accountability
requirements. The Australian
Government has also com-
misioned an independent examina-
tion of long-term financing
options for the residential aged
care sector. Over the next 40
years, Australian Government
spending on long-term care is
projected to more than double,
from 0.72 to 1.77 percent of GDP,
due to the doubling of the over-
65 population and growing
demands for new technologies.

Quality assurance (QA) and
staffing represent two other
important issues related to long-
term care delivery in Australia.
With respect to QA, the 1997
reforms introduced a system of
accreditation aimed at improving
quality of care. In 1999, the
Australian Government and the
aged care sector agreed on a
10-year forward plan to further
improve the quality and safety of
residential facilities. The
Australian Government has also
put in place a range of measures
to safeguard and enhance con-
sumer rights. With respect to
staffing, the long-term care
industry in Australia has had dif-
culties in recruiting and retain-
ing appropriately educated and
skilled staff. To help with this
issue, the 2002-2003 government
budget commits AUD47.5
million over four years to
encourage more people from
rural and regional areas of
Australia to enter or re-enter
long-term care nursing, and to
support the education and train-
ing of workers in smaller homes.

The New Zealand Experience
The Honorable Annette King,
Minister of Health of New
Zealand, reviewed her country’s
experience with respect to long-
term care. Health and social care
in New Zealand is funded pre-
dominantly through taxation,
with a small private insurance
market for health care. New
Zealand has adopted the World
Health Organization concept of
“active aging” in developing poli-
cies related to older people. The
New Zealand Positive Ageing
Strategy, published in 2001, pro-
vides a framework within which
all policies with implications for
older people are developed. The
health and long-term care com-
ponent of the strategy focuses on
supporting people to live at home
for as long as it is safe and desir-
able to do so. (See full proceed-
ings for details on government-
supported initiatives that support this strategy.)

In October 2003, funding for disability support services for older people was devolved to 21 District Health Boards with responsibility for maintaining and improving the health of the population in their districts. The hope is that these District Health Boards will develop a continuum of care for the elderly, with incentives to focus on health promotion, disease prevention, and early intervention.

The majority of New Zealanders who need long-term care still live in their home. In fact, almost three-quarters (72 percent) of those age 85 and over live at home, 15 percent of whom live without any assistance. For those who need assistance, needs assessment and service coordination agencies undertake holistic assessments of needs, and work with individuals to develop a customized support package to meet these needs. These agencies have succeeded in reducing entry rates to residential care to a rate below that of the population growth in older age groups. At the same time the number of people receiving community support services has increased.

People age 65 and over who are assessed as needing long-term residential care can apply for a subsidy to cover all or part of the costs of their care. Access to a subsidy is means-tested based on income and assets. Most residential care is provided in the private sector in partnership with the government. Quality of care is monitored in part through the Health and Disability Sector Standards, which require residential care providers to establish safe practices and continuous quality improvement systems.

Looking ahead, New Zealand must grapple with an issue facing many other nations—workforce shortages. New Zealand faces workforce shortages across a range of health settings, including in long-term care, where there is a general shortage of registered nurses. To address this issue, training programs for caregivers, which in the past have developed in ad hoc ways, are now becoming more consistent across the nation. In addition, work is underway to develop minimum staffing levels in residential care facilities.

**Conclusion**

Ms. LeaMond closed the proceedings by noting that sharing “best practices” and innovative ideas can be extremely helpful to policymakers in the U.S. and other nations as they struggle to find strategies for addressing the tremendous challenges involved in providing timely, affordable, efficient, and high-quality long-term care services to everyone who needs them.
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<td>William D. Novelli, Executive Director and CEO, AARP</td>
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<td>The Challenge of Long-Term Care: A Search for Solutions</td>
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<td>The 2004 Long-Term Care Study: Preliminary Findings</td>
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<td>Franz Knieps, Director General for Health Care, Health Insurance</td>
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<td>and Nursing Services, Federal Ministry for Health and Social Security,</td>
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<td>Joshua M. Wiener, Ph.D., RTI Fellow and Program Director, Aging,</td>
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<td>John Creighton Campbell, Ph.D., Professor of Political Science,</td>
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<td>University of Michigan, Expert on Long-Term Care Policy in Japan</td>
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<td>Reforms and Best Practices in New Zealand and Australia</td>
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<td>The Honorable Annette King, Minister of Health,</td>
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<td>Nancy A. LeaMond, Director, Office of International Affairs, AARP</td>
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Proceedings

AARP International Forum on Long-Term Care

As a part of its Global Aging Program, AARP held a half-day forum on October 22, 2003 that examined how European countries (including Germany, the Netherlands, and the United Kingdom), Australia, New Zealand, and Japan have developed and/or reformed their policies with respect to long-term care in an effort to make available—and empower consumers to choose from—a wide array of affordable, high-quality services. The primary goal was to understand the lessons that these countries' experiences might offer for the United States.

Welcome
Nancy LeaMond, Director of International Affairs at AARP, began the proceedings by noting that reforming policies related to long-term care, and promoting the ability of individuals to live independently as long as possible, represent very important issues in the U.S. and most other nations. She also introduced William D. Novelli, Chief Executive Officer of AARP. Mr. Novelli emphasized how much different countries have to learn from each other on issues related to aging, noting that most countries are wrestling with similar issues, albeit in somewhat different ways and from different points on the aging curve. He called for a movement beyond "doomsday" predictions about the future impact of aging on various societies to a realistic but practical look at the opportunities presented by aging. Through its Global Aging Program, AARP is trying to encourage a dialogue among health care leaders in various countries to develop policies and programs that represent realistic, practical solutions that can work.

Many of these policies need to relate to one of the biggest issues facing most if not all countries—how to finance long-term care. But there are also other issues related to long-term care that must be addressed. Consumers throughout the world have made it clear that they want long-term independence, not long-term care. Consumers want options and choices, and they fear losing independence and control. But many people view the options they have today in
Consumers want long-term independence, not long-term care.

long-term care as being somewhere between “useless” and “harmful,” and they increasingly doubt that they will receive high-quality services if they need help.

For their part, public policy decision-makers fear the mounting costs of public reimbursement programs, while providers fear that tightening reimbursement will make it impossible to meet the growing demands for higher quality services from regulators and consumers. These mutual fears and distrust threaten a downward spiral of budget cuts, quality problems, and litigation. To address these fears, governments need to look beyond the immediate budget crunch to the opportunity to make systemic changes to promote consumer choice and enhance the quality of services. Improvements must be made to the public and private financing of services, which will in turn improve quality. But more money will not fix the problem unless the money is spent wisely. Placing the decisions and the money in the hands of consumers will enhance their choices and their responsibilities in monitoring their own care. It will also make providers more responsive to consumers, which should spur innovation and quality improvements. In closing, Mr. Novelli quoted former First Lady Rosalynn Carter, who noted that “there are four kinds of people in the world: those who have been caregivers; those who currently are caregivers; those who will be caregivers; and those who will need caregivers.” In other words, long-term care is an issue that affects everyone. Given the dramatic demographic changes ahead, which are in addition to the immense needs of today, a way must be found to finance appropriate, high-quality, affordable long-term care services to those who need them today, as well as to the many more who will need them in the future.

The Challenge of Long-Term Care: A Search for Solutions

Following Mr. Novelli’s opening remarks, Joanne Disch, Ph.D., R.N., F.A.A.N., an AARP Board Member and Professor and Director of the Katharine J. Densford International Center for Nursing Leadership at the University of Minnesota, discussed the search for solutions to the challenge of long-term care by reviewing international approaches to the financing and delivery of such care.

She began by noting that the phenomenon of an aging nation is not uniquely American, but rather a worldwide issue with challenges and opportunities that know no boundaries, and with implications that affect the world’s interconnected economies and societies. As evidence of this, she cited the following statistics that show that global aging is an issue that is not going away:
• More than half of all human beings who have ever lived to age 65 are alive today.

• In 2002, over 15 percent of the populations of France, Germany, Italy, Japan, the United Kingdom (U.K.) and the U.S. were over the age of 50. By 2050, more than 26 percent of the population in these countries will be at least 60, with Japan and Italy leading the way at 42 percent.

• In the U.S., the fastest growing population segment is people 85 years of age and over, and the second fastest growing segment is those who have celebrated their 100th birthday.

Dr. Disch noted that during her 35-year nursing career she has seen both “the good and the bad” parts of long-term care in the U.S. She has seen wonderful, selfless work being done by family members and staff in facilities that care for the elderly, and has also seen abuse, disrespect, and cruelty. In fact, she believes that the elderly, not children, may be the most vulnerable people in society. While the challenges of child care are foreseeable and often planned for, the need to care for an elderly family member often comes about suddenly and unexpectedly. Those who enter this role may be unprepared and resentful.

Like Mr. Novelli, Dr. Disch emphasized that the needs of older people can and should be met in an environment of their choice, which surveys suggest is usually the home (as long as there is easy access to community-based services). Modifications in the home and technological supports make this a viable option for more people today. That said, some individuals still need to receive services in assisted living facilities such as residential care apartment complexes. The level of assistance offered in these facilities varies. Often, home- and community-based services are a less expensive option to nursing homes, although at times nursing homes will also be necessary. But regardless of the setting, the key challenge facing countries is to create a situation where people receive quality care that is accessible and affordable to all who need it.

Different countries have tried to meet this challenge in different ways. Many are trying to introduce the concept of consumer-directed home care, which gives individuals, rather than agencies, control over the provision and delivery of home health services. (Dr. Disch reviewed key findings from a recently completed study published by the AARP Public Policy Institute on consumer-directed home care, which is described in more detail later in this report.) These programs are being developed in response to research showing that the elderly
and people with functional challenges want more choices and control in their lives, which was also a key finding in AARP’s latest report in its “Beyond 50” series, entitled Beyond 50.03: A Report to the Nation on Independent Living and Disability. Individual states within the U.S. are also getting the message, and as a result the number of consumer-directed programs is growing. A 2001 survey conducted by the U.S. General Accounting Office shows that only two states do not offer at least one consumer-directed program. Dr. Disch highlighted examples of innovative state programs:

• **Indiana’s CHOICE** (Community and Home Options to Institutional Care for the Elderly and Disabled) Program has been recognized nationally as a model for providing consumer-driven home- and community-based care. This state-funded program allows local case managers to work directly with consumers and families to define a plan of care to meet their needs, and then to broker with local providers for the best price. Also in Indiana, legislation has unanimously passed both Houses of the General Assembly that will shift state spending on nursing homes to home- and community-based services, and that will allow public funds to “follow” the individual so that people can receive care where they need it.

• In the state of Wisconsin, the **Family Care** program is designed to provide cost-effective, comprehensive long-term care that fosters the consumers’ independence and quality of life, while recognizing the need for interdependence and support. The two major organizational components to the program are aging and disability resource centers, designed to be single entry points where older people and people with disabilities and their families can get information and advice about a wide range of available resources, and care management organizations that manage and deliver benefits that are tailored to each individual’s needs, circumstances, and preferences. Wisconsin also offers a Partnership Program that integrates health and long-term support services. Services are delivered in the participant’s home or a setting of his or her choice. A key component of this program is team-based care management in which the participant, his or her physician, and a team of nurses and social workers develop a care plan together.

**The 2004 Long-Term Care Study: Preliminary Findings**

Jeremy Hurst, head of the Health Policy Unit of the Organization for Economic Cooperation and Development (OECD), reviewed the preliminary findings from the long-term care portion of the

More than half of all human beings who have ever lived to age 65 are alive today.
OECD’s Health Project (2001-2003), which is based on a review of 18 countries that represent a variety of different types of health and long-term care systems. The final report is scheduled for release in 2004. The goal of the study on long-term care is to identify lessons that can be learned from recent structural reforms and changes in these 19 countries, including those related to the following: providing more responsive services and consumer choice, improving quality, paying for services, and improving the quality of comparative data on long-term care across countries. Key findings related to expenditures on long-term care include the following:

- Countries spend up to 2.5 percent of their GDP on long-term care, although most spend less.

- Institutional care still dominates spending, although most countries are trying to shift resources to home-based care. In some countries these efforts have been successful, with home-based care representing almost half of all public spending on long-term care.

- Private spending is even more concentrated in institutional care, although the contributions of informal care at home are not included in private spending figures.

- Not surprisingly, expenditures on long-term care are disproportionately concentrated on the very old. Mr. Hurst noted that this fact, combined with the aging of the population, likely means that expenditures on long-term care may accelerate in the future in many nations.

- The government’s share of total funding for long-term care has increased significantly in Germany, Japan, and Luxembourg, countries that recently enacted new social insurance schemes for long-term care. Growth in the U.S. and U.K. has been more incremental, and is primarily driven by tax-funded health systems to meet more nursing home costs. By contrast, in Australia and Sweden, growth in spending has been quite low, as concerns about the sustainability of public programs have led to a targeting of benefits and an increased responsibility for the private sector.

Out-of-pocket expenditures for long-term care are much higher than for acute health care in most OECD countries.

- Out-of-pocket (OOP) expenditures for long-term care are much higher than for acute health care in most OECD countries. There is an ongoing debate in a number of countries about the fairness of the burden of these OOP costs. In addition, the budgets of local and regional social assistance programs bear the burden when users cannot pay for services. This problem has been a driver of recent reforms in Germany, and
has spurred debates in other countries.

• Private long-term care insurance (PLTCI) is growing in some countries, albeit from a very low base. Voluntary PLTCI has had limited growth due to a variety of factors (e.g., the high cost to consumers). In the U.S., voluntary PLTCI covers 11 percent of total costs for long-term care. PLTCI has enjoyed more rapid growth when it is compulsory, as in Germany where higher-income groups who opt out of the public insurance scheme must purchase private health and long-term care insurance.

• While the ability to compare costs over time and across countries is limited, available evidence suggests that increases in expenditures are currently being driven more by policies to expand services (in response to growing public expectations and social change) than by the aging of the population.

The study also will examine policy issues and trends related to consumer-directed care, consumer choice, and direct payment schemes designed to facilitate such choice. Key findings from this aspect of the study include the following:

• There is a trend toward more choice and participation for users of long-term care services.

• Support for home- and community-based care as an alternative to institutional care is growing.

• Policies to sustain the efforts of informal caregivers are gaining in popularity, in part as a way to reduce costs by decreasing the need for institutional care and formal care at home.

• Consumers are increasingly being given the choice between having agencies hire and direct their care assistants and being allowed to do this on their own.

• Competition and the growth of local “markets” for home care is increasingly being seen as a means to improve quality and cost-efficiency, provided appropriate regulations are in place.

• Countries differ in the way that consumer-directed care programs are organized. Some countries, such as the U.K., Netherlands, Norway, and Sweden, use personal budgets and consumer-directed employment of care assistants. As an alternative or complement to this practice, some countries, including Austria, Germany, and Sweden, make direct payments to the persons needing care. A third approach, used by Australia, Japan, and Sweden, involves giving payments to informal caregivers as a means of income support.
A third part of the long-term care study will attempt to project future expenditures based on a variety of assumptions about population growth, demographic trends, and economic growth. One analysis concluded that the proportion of GDP spent by governments on long-term care will double between 2000 and 2050. As depicted in the chart below, the average OECD country will spend a projected 3.3 percent of GDP on long-term care. Mr. Hurst cautioned, however, that these projections are highly sensitive to the underlying assumptions used to make the forecast.

Mr. Hurst reviewed several key lessons from the OECD report:

• A number of challenges exist related to coverage and coordination of services. For example, home care bridges the traditional division between health, social, and employment policy. In addition, different countries vary in the role played by social assistance programs as the financier of last resort. Finally, challenges persist in securing adequate coverage for those with the most severe disabilities, including severe dementia.

• There is a need for broad networks of community support services, including respite care, training, and support groups. These networks are at various stages of development in OECD countries. Geographical disparities in the supply of long-term care services remain a challenge for many countries.

• With respect to women caregivers, long-term care policies often reflect the traditional role of families and of women as informal caregivers. There are marked differences across OECD countries in the participation rates of women in the labor market, especially women between the ages of 50 and 65.

Mr. Hurst concluded his remarks by looking to the future with respect to the health of older persons, highlighting three key questions related to long-term care:

• Is the health of older persons improving fast enough to compensate for the aging of the population?

• Will the emerging obesity epidemic endanger the health gains of the last two decades?

• What is the role for local action on health promotion and disease prevention to facilitate “healthy” aging?

Lessons from Abroad: International Approaches to Long-Term Care
The forum included a panel in which four experts described the approaches to long-term care that are being taken by other countries, drawing out potential lessons for the U.S. John Rother,
Director of Policy and Strategy at AARP, moderated the session. He began by noting that while long-term care has historically suffered from neglect in the U.S., its time is now coming. Thus, it is appropriate to analyze and draw lessons from the experiences of other countries. Mr. Rother believes that the issues surrounding long-term care go beyond simply offering services to those who need them. This multi-dimensional issue is about living with and adapting to a loss of functionality. Addressing it requires solutions to a variety of issues, including how to provide consumers with choices, support caregivers, and intervene early to maximize functional capacity.

The German Experience
Franz Knieps, Director General for Health Care, Health Insurance, and Nursing Services at the Federal Ministry for Health and Social Security in Germany, described the German system for long-term care. He began by noting that long-term care is one of the most important issues facing the country over the next 20 years.

The System in Brief
Germany’s long-term care system is financed primarily through public funds raised through income taxes paid by individuals and employers. The system is part of the nation’s social insurance system, which also provides health insurance. Roughly 90 percent of Germans are enrolled in the public system; the remaining 10 percent, composed primarily of the wealthy, “opt out” of the public system, instead purchasing mandatory private health and long-term care insurance. In 2002, Germany’s public long-term care insurance program cost 17 billion euros, providing subsidized care to approximately two million Germans.

The Reform Process
Germany recently enacted a series of reforms with respect to long-term care. These reforms were implemented incrementally in a series of steps. The overall goal was to reduce dependency on expensive, institutional care in favor of less expensive home- and community-based settings. The reforms have met this goal—before they were enacted, 80 percent of those needing long-term care were served in institutional settings. Today that figure is only 25 percent. The first step in the German reforms was to establish a minimum home care benefit for all Germans in the public system. Interestingly, to help finance this benefit, the German government collected tax revenues for four months before paying out any benefits. Three different levels of service were established based on the individual’s needs, ranging from relatively minimal care needs to more comprehensive needs. There is no means-testing
to qualify, and individuals do not have to first use their own resources to receive home health services paid for by the government.

The second step in the German reforms was to allow those who receive care from family members or other acquaintances to opt out of the agency-based system, and to instead pay the caregiver directly for providing these services. Those informal caregivers who work a minimum number of hours each week qualify for pension and health benefits.

The third step in the German reforms was to redefine the institutional benefit so that it became equal to the benefit for home health services. This “total fiscal equalization system” applied to all funds, both public and private, so that strong incentives were created to use more cost-effective home-based services. Not surprisingly, these reforms have resulted in a dramatic expansion of the infrastructure for long-term care, particularly with respect to home health services. (The supply of nursing homes and other institutional-based long-term care services was already adequate.) These provider organizations contract with the health funds to provide services to those who need it.

The final step in the German reforms was to enact safeguards to better ensure the quality of services in nursing homes, including bolstering the rights of residents of these homes.

**Plans for the Future**

Looking ahead, Germany plans to continue reforming and improving the long-term care system. One of the key challenges facing the system is how to strengthen support and care for patients with dementia and their family members. Giving these families a personal care budget and a range of services from which to choose has been a good first step, but more is needed. Another challenge relates to controlling the overall costs of long-term care, keeping growth in line with income growth and/or the rate of inflation. Other issues to be addressed include the following: improving the situation for family members of those receiving long-term care; integrating the long-term care and health insurance systems; and equalizing the amount of money allocated to institutional and “outpatient” (e.g., home health) long-term care services.

Finally, some of the challenges facing the German long-term care system are similar to those facing other components of the German social insurance system, including pension funds and health insurance. Most of these issues relate to the financing of services, including the dependence of the social insurance
system on labor-based taxes. While the long-term care system has thus far fulfilled its mission and reached its near-term goals, the ability to continue to serve Germans well will depend upon the ability to address these issues, including reducing this level of dependence.

The Dutch Experience
P. J. van de Kasteele, Deputy Director of the Department of Residential and Domiciliary Care and Seniors’ Policy at the Ministry of Health, Welfare, and Sports in The Netherlands, offered an overview of the Dutch system for long-term care. A geographically small country with 16 million residents, the Dutch system has been influenced by the country’s small size and high population density.

History of the System
The system’s roots go back to the 19th century, when voluntary organizations (e.g., religious organizations) set up home care services, following a tradition that dates back to the middle ages. While some residential homes for the elderly were built 100 years ago, construction of these facilities accelerated following World War II, primarily in response to a severe housing shortage caused by the devastation of the war. The nursing home industry also began many years ago. They were set up as “hospitals without doctors” with a strong focus on medical services. The economic boom of the 1960s encouraged the Dutch government to enact a broad social insurance scheme for the whole population, one that originally covered only nursing home care. Over time the benefits expanded to include home nursing care in the 1970s, home care in the 1990s, and residential home care as of 2001.

The System Today
Today the system covers the entire population and is financed through income taxes. Total projected costs are $13 billion annually, equivalent to 2.7 percent of the Dutch GDP. The long-term care benefit is administered by health insurance companies that contract with the providers of services. Patients pay copayments at the time of service (based on their level of income), but do not see a bill for services. Utilization of care is overseen by an independent regional authority that assesses the need for care, while prices are regulated by law and overseen by a tariff council.

Roughly 90 percent of Germans are enrolled in the public long-term care system; the remaining 10 percent, primarily the wealthy, purchase mandatory private health and long-term care insurance.
care is no longer possible. Approximately 1,400 residential homes exist in the Netherlands, with facilities located in every town in the country; these homes have the capacity to serve 110,000 individuals, or roughly 11.5 percent of all those over the age of 75, although the average age of admission is 83 and the average stay is just under four years. These facilities serve primarily low-income residents, as the wealthy prefer to pay for private service apartments on their own. And for those who need nursing home care, 330 nursing homes have a capacity of 60,000 beds (equivalent to roughly six percent of the population over the age of 75).

The Ministry of Education is responsible for vocational and professional schooling of those interested in careers in long-term care, and for training of staff in facilities. A division of the Ministry of Health projects the need for different types of medical specialists and works with the Ministry of Education to plan for schooling. The ability to attract workers to long-term care depends primarily on the state of the economy. In boom times it is difficult to find workers because they have so many other opportunities. The current economic slump means that finding less skilled workers is not a problem, although workers with higher levels of vocational training are still in short supply. In addition, because nurses can make more money in hospitals, it is difficult to attract them to long-term care settings.

Long-term care providers are not required to use any particular type of staff mix. They are required to have a quality assurance plan, and are subject to periodic inspections that focus on the existence and implementation of those plans. More detailed inspections are reserved for those organizations that receive specific complaints. Anyone who wants to build a new facility must receive approval from the Ministry of Health, which checks plans against existing standards.

Problems
The biggest problem facing the Dutch system is that patients do not pay their own bills, meaning that no one outside the government has much of an interest in cost control. This problem will become worse over the next 40 years, as the number of people age 75 and over is expected to double during this period. The net result will be fewer young people to support more elderly people who need long-term care. The government has made efforts to control costs in the past, primarily by limiting the building of new facilities. As a result, there are waiting lists for services. For nursing homes the wait list equals 15 percent of total

Total projected costs for long-term care in The Netherlands are $13 billion annually, equivalent to 2.7 percent of the GDP.
capacity, and for residential homes it is around 30 percent. A major building program will ensue in the years ahead to address this problem. A recent analysis concluded that more than half of the production of new houses over the next decade should be targeted for the elderly.

**Future Reforms**

The focus of the Dutch government going forward will be to emphasize home-based care rather than institutional care. This way of thinking represents a change for the boards of nursing homes and residential care facilities, who tend to want to protect their buildings. In addition, the government is beginning to rethink its financing of comprehensive benefits for the entire population. It may no longer be possible to provide all needed care to all individuals. Some benefits can potentially be paid by individuals themselves. And in some cases, local governments may be able to finance services rather than the federal government. In addition, the government is looking for ways to introduce regulated market conditions into the delivery of care, so as to create an economic incentive for insurers, providers, and patients to improve the efficiency of the system. Specific reform ideas in this area relate to giving providers more risk and more freedom, and introducing new copayments for patients. Through a mixture of these measures, the Dutch government hopes to keep long-term care accessible and affordable for those who need it, even as the elderly population increases substantially in the years ahead.

**Consumer-Directed Home Care in The Netherlands, England, and Germany**

Joshua M. Wiener, Ph.D., RTI Fellow and Program Director for Aging, Disability, and Long-Term Care at RTI International, reviewed the results of a recently published study comparing consumer-directed home care in the Netherlands, England, and Germany. The study was supported by AARP’s Public Policy Institute, with the goal of understanding what the experiences of these countries can tell the U.S. about how to make sound long-term care policies.

The study focused on evaluating the degree of consumer control with respect to organizing home care. While a substantial portion of care is handled by agencies in these countries, a growing movement is underway to allow consumers to have their own budgets and/or to direct their own care by hiring, monitoring, and even firing their own home care workers. The goal of these programs is to empower persons with disabilities by giving them more control over their own lives, and to foster competition among home care providers, which should lead to better quality and more cost-
effective services. While these programs originated with younger persons with disabilities, they are now being expanded to include older people as well. In the U.S., these programs have appeal to individuals on both sides of the political spectrum, as conservatives are attracted to the market-based nature of the system while liberals like the notion of empowering people with disabilities. Several states, including California, Michigan, Oregon, Washington, and Wisconsin, are experimenting with consumer directed care. In addition, Arkansas, New Jersey and Florida are experimenting with “cash-and-counseling” demonstrations, a pilot project of the U.S. Department of Health and Human Services with support from the Robert Wood Johnson Foundation.

**Comparing the Different Systems**

Dr. Wiener noted that all three countries in the study offer a long-term care benefit to citizens. While England’s system is means-tested at the local government level, Germany and The Netherlands provide the benefit to all citizens as part of universal social insurance systems. (As noted earlier, wealthier Germans can opt out of this system, but must purchase private long-term care insurance if they do.) Dr. Wiener compared the consumer-directed home care programs in the three countries along several dimensions.

**Choice and Home Care Benefit:**

All three countries offer choice. The Netherlands provides a personal budget that is based on projected agency costs, less 25 percent and an income-related copayment. England provides direct payments based on a “bottom-up” analysis of the number of hours needed. Germany provides a cash payment to citizens that equals between 40 percent and 50 percent of agency costs, with payments varying by disability category.

In the Netherlands and England, all money paid must be spent on services, while in Germany there are no such restrictions. In the Netherlands and Germany, money can be paid to support informal caregivers, such as family members. Due to restrictions on how the money can be spent, the administration of the benefit is quite complicated in the Netherlands and England, as safeguards are put in place to protect workers and prevent abuses. The German system is simple to administer due to the lack of restrictions.

**Size and Growth of Program:**

The number of beneficiaries who have opted for consumer-directed care varies widely across countries and across patient
characteristics (e.g., age, number and severity of disabilities). In the Netherlands roughly one in 10 of those receiving home care services has opted for consumer-directed home care. This figure is growing rapidly due to supply constraints among agencies. In England the comparable figure is only about two percent, due in part to local resistance. The national government is promoting the program more heavily, however, and some growth has occurred as a result. In Germany the program is very popular, with 75 percent of those receiving home health services opting for the cash payment.

Informal Caregivers: The role of informal caregivers in consumer-directed programs also varies across the countries. In the Netherlands spouses and parents are heavily involved, as they are seen as important parts of the system. In England, close relatives are explicitly excluded from the system, as the government does not want to pay for services that would have been provided anyway. The German government mostly conceives of the cash payment as a way of supporting informal caregivers.

Cost Containment: Each of the countries also views the programs as a way to contain costs compared to agency-based care. Both the Netherlands and England do not pay for agency overhead within their consumer-directed programs, and, as noted previously, Germany pays only 40 to 50 percent of the service benefit. That said, because these systems offer an attractive benefit (including cash in some cases), it is possible that utilization—and total spending—may actually increase. (The study did not look at this issue.)

Quality Assurance: Each of the consumer-directed systems in the study lacks traditional quality assurance mechanisms. While all three have minimal external review, oversight is not nearly as stringent as for agency-directed care. Instead, these programs rely on other factors, including the consumer (who can hire and fire workers), competition across providers, and (in the Netherlands and Germany) the bond between family members, to ensure the provision of high-quality services.

Conclusion
Dr. Wiener concluded by noting that the popularity of consumer-directed home care is growing in all three countries, and that the programs extend beyond the younger disabled population to include the elderly and those with severe disabilities. Looking ahead, he expects consumer-directed home care to play an increasingly important role in these and other countries as a way of empowering people with disabilities.
The Japanese Experience
John Creighton Campbell, Ph.D., Professor of Political Science at the University of Michigan and an expert on social policy in Japan, reviewed Japan’s startling innovation in long-term care policy. The Japanese system is a public, mandatory, social insurance system in which all individuals over the age of 40 pay premiums based on income, and all those aged 65 and over are eligible for services, with eligibility determined by an activities of daily living (ADL) test. Neither income nor the availability of family care is taken into account. General tax revenues finance roughly half of the system, with the remainder coming from the premiums paid by workers and seniors themselves. Approximately 3.5 million individuals — equivalent to 14 percent of the 65-and-over population — have been certified as in need of services. Total costs are equal to about $30 billion a year in purchasing-power-parity dollars. By 2010, that figure is expected to rise to $70 billion, or 1.5 percent of GDP.

A Shift in Thinking: The current Japanese system is the product of reforms that began in 1990. The policy change was called “socialization of care” since some of the risk of being frail has been shifted from the individual or family to the population at large. This notion of shifting risk goes beyond the safety-net concept of the U.S. and the “family-first” approach in some European countries.

Until 1990, Japan had adopted a safety-net approach. But due to a variety of factors, the Japanese decided that a new approach was needed. First and foremost, Japan has the most rapidly aging population in the world, with more than 20 percent of the population over the age of 65. In addition, the traditional role of women in Japanese society has been changing rapidly. More women have entered the workforce and thus cannot take care of elderly family members. The Japanese government also faced a policy problem in the early 1990s, as too many elderly individuals were receiving long-term care in the hospital setting, pushing public health insurance programs into financial deficits. Finally, politics played a role as well. The Liberal Democratic Party (LDP) made the “aging society” problem a central part of its campaign slogan in 1990. These factors led to a view that long-term care was not just a problem for individuals to deal

History of the System
Dr. Campbell provided a brief history of how this system came into place in Japan, a country that historically has not been known for large or innovative welfare and social insurance programs.
The Initial Plans: In 1990, the LDP released its first Gold Plan that laid out 10-year targets to double or even triple service levels for various long-term care services, with an emphasis on community care. Demand exceeded expectations about the extent to which Japanese citizens (especially women) wanted to shift the burden of taking care of family members to an outside agency. The targets had to be raised still higher in the “new Gold Plan” in 1994. As services expanded, however, problems of inconsistent eligibility, bureaucratic administration, and the inevitability of new taxes led policymakers to seek a different solution.

The Current Plan: Specialists in and around the Ministry of Health and Welfare (MHLW) began intensive discussion, including a look at planning for the German LTCI system in the early 1990s. They turned to a social insurance system financed half through earmarked premiums, eliminating the need for new taxes, and bypassing the welfare bureaucracy in favor of individual entitlement and consumer choice. The current long-term care insurance scheme was passed in 1997 and implemented in 2000.

Differences from the German System
While Japanese officials studied the German system, they did not copy it completely. The Japanese system does not cover all ages, but rather only those age 65 and over. But Japan’s program is much bigger—while both programs began at 0.7 percent of GDP, Japan’s is expected to double while Germany’s stays flat as a percent of GDP. The higher costs in Japan are due in part to the fact that more people are eligible in Japan—14 percent of those age 65 and over, compared to 8 percent in Germany. Japan also offers higher benefits than does Germany at a given level of disability. One reason why Japan’s program is so big is that the country already was doing a lot before 1997. Roughly 400,000 individuals were already getting free long-term care in hospitals as a part of the country’s health insurance system. In addition, the original Gold Plan had resulted in rapid growth (roughly 15 percent annually) in community-based services. Although future spending would obviously rise substantially, for whatever reason, in Japan there was no real fight over finding money to finance the program.

Another difference between the Japanese and German systems relates to the role of informal caregivers; Germany supports family care, while in Japan...
benefits must be received from community-based organizations. This is because Germany was trying to preserve the traditional women’s role as a caregiver, while Japan was trying to transform it, due, in part, to persuasive arguments by feminists.

The Results Thus Far
The Japanese program has worked well so far. Implementation proceeded smoothly, with 2.5 million Japanese citizens certified for eligibility in the first year. While the media publicized complaints about how some individuals had to pay large income-related premiums and copayments (as opposed to getting free care before), these complaints were not widespread and local governments provided assistance to citizens facing extreme hardship.

The program has grown rapidly, by 45 percent over three years in terms of both funding and the number of people served. After three years it is widely accepted as a normal part of Japanese social policy.

Lessons Learned
Dr. Campbell concluded by reviewing the lessons learned from the Japanese system. First, he reiterated the importance of looking for lessons from other systems. With that in mind, he noted that the Japanese experience demonstrates that providing access to comprehensive long-term care is feasible and does not entail the same level of risk associated with medical care. Long-term care is not a “branch” of health care; benefits can be limited to keep costs affordable. The big choice facing nations is whether to adopt a direct services model or a social insurance model, a choice that depends somewhat on the history and culture of a nation. That said, Japan switched course from an agency-based to a social insurance system. Finally, the Japanese model suggests that paying for services only (as opposed to offering a cash benefit) can result in cost savings. Evidence suggests that beneficiaries in Japan consume only about 40 percent of the services for which they are eligible. But as the German experience suggests, almost everyone will take cash when offered.

Reforms and Best Practices in Australia and New Zealand
The final two presentations focused on the reform experiences of Australia and New Zealand.

The Australian Experience
Philip Davies, Deputy Secretary of the Department of Health and Ageing in Australia, provided an overview of Australia’s reform process, a brief discussion of financing issues for residential aged care, and insight into quality and staffing issues.
Overview of the System and the Reform Process

Mr. Davies began by describing the current long-term care system in Australia. Residential aged care services are funded by the Australian Government (the federal government) and are run mostly by either for-profit or not-for-profit organizations. Home-based care services are either provided under the joint federal and state Home and Community Care Program or by the Australian government’s Community Aged Care Packages. The Australian government also funds a number of programs to assist caregivers.

Over the past twenty years, the Australian long-term care system has undergone significant change as part of an ongoing reform and review process. In the mid-1980s, the Australian Government introduced a service provision benchmark for residential care, based on the number of people age 70 and over. The aim was to meet the increasing demand for residential care as Australia’s population aged, while also effectively managing government outlays in a sustainable way. In October 1997, the Australian Government introduced a structural reform package to produce a more seamless and sustainable system of long-term care delivery. The existing policy framework at that time was widely regarded as being incapable of servicing Australia’s needs into the future. Problems included a poor quality building stock (especially in the nursing home sector), inflexible care provision, complicated administrative processes, a weak quality assurance system, and unsustainable reliance on Australian Government funding.

The reform package included unification of ‘low-care’ hostels and ‘high-care’ nursing homes under one system; introduction of a single classification and funding tool to cover the full spectrum of care needs; introduction of greater flexibility for respite care; a greater focus on sustainability through user contributions in the form of daily care fees, income-tested fees, and accommodation payments; an extra service scheme that enables residents to access a higher standard of accommodation, food and other ‘hotel’ services at a higher charge; and a standards framework to underpin quality assurance.

The reform package, known as the Aged Care Act 1997, has been the subject of ongoing review. A recent two-year review found that it had improved access to community care for people wishing to be cared for in their own homes and improved access to care for people with the highest levels of dependency. The review also found that user contributions had increased, and that the industry’s viability had been
enhanced, leading to extensive investment in building, upgrading, and refurbishing.

In recent years, the Australian Government has substantially expanded the number of non-residential care options. In fact, the number of Community Aged Care Packages grew from 4,944 in 1995 to 27,996 in 2003, while the Home and Community Care Program expanded to provide services to an estimated 700,000 people in 2002-03. In addition, the Australian Government is providing a number of older people with high-level care through the Extended Aged Care in the Home program, which was declared a mainstream program earlier this year after being piloted for several years. The Australian Government also substantially increased funding for a number of programs to assist caregivers.

**Issues for the Future**

In March 2002, the Federal Minister for Ageing initiated an informal review of community care programs in response to community and industry concerns that the current system is too complex for users. Based on this review, *A New Strategy for Community Care Consultation Paper* was released in March 2003 that broadly outlines the Australian Government’s proposed reforms. The four key elements of the strategy are:

- Aligning services with levels of need.
- Developing a common access framework.
- Reducing duplication in assessment and data collection.
- Streamlining administrative and accountability requirements.

**Financing Issues:** The Australian Government has also commissioned an independent review of pricing arrangements in residential aged care. The pricing review is examining long-term financing options for the residential aged care sector, including the interaction of residential care with community care and other aged care and health programs. Recommendations will be made by the end of 2003. These recommendations will address strategies for controlling the rapid growth that has occurred in Australian Government funding for community care and caregiver support in recent years. Since 1995-96, funding for the Home and Community Care Program has increased by over 73%, while funding for Community Aged Care Packages has jumped by 770%. Australian Government funding for a respite program has increased by over 380% since its inception in 1996-97. Left unchecked, these increases could cause serious fiscal problems in the years ahead. In fact, as part of the 2002-2003 budget, the Australian Government released
an Intergenerational Report that assessed the long term fiscal impact of current policies over the next forty years. The report identified an emerging gap between government revenue and expenditure, with increased health and long-term care expenditures accounting for a large part of the projected gap. Over the next 40 years, Australian Government spending on long-term care is projected to more than double, from 0.72 to 1.77 percent of GDP. Spending on residential aged care alone is projected to increase from 0.58 to 1.45 percent of GDP in the same period. The rapid escalation in projected costs is due to two main factors: first, a doubling of people aged 65 and over during the next four decades, and, second, consumer demands for access to the many rapid technological advancements in health care.

Looking ahead, it will be necessary to consider how the total costs of aged care will be allocated across governments and individuals/families. The financing of aged care can be thought of as an ongoing negotiation of cost sharing and cost shifting between different groups in society, including recipients and non-recipients. These negotiations occur across generations, across and within levels of government, across income and wealth status, and across health status.

**Quality Issues**: Quality assurance is another big issue surrounding long-term care delivery in Australia. Under its 1997 reforms, the Australian Government introduced a system of accreditation aimed at improving quality of care. Accreditation is a quality-based assessment against standards in management, staffing, health and personal care, resident lifestyle, and physical environment and safety. To be eligible for the Australian Government subsidy, homes must be accredited by an independent body. In addition, under the certification program, residential homes are encouraged to improve building quality beyond the basic requirements to meet rising consumer expectations. In 1999, the Australian Government and the aged care sector agreed on a 10-year forward plan to further improve the quality and safety of homes in the medium term, and to enhance privacy and space in the long term. Certification allows residential homes to receive revenue streams and other funds (e.g., accommodation payments, bonds) that can be used to upgrade the physical quality of buildings. Finally, the Australian Government has put in place a range of measures to safeguard and enhance consumer rights, and to provide support for those who may be culturally or socially isolated.
Staffing Issues: Long-term care in Australia is primarily provided by registered nurses, enrolled nurses, and personal care assistants. The Australian Government does not set wages for nursing staff, nor does it prescribe staffing ratios or minimum qualifications for staff. Providers design their own staffing and resource plans. However the Australian Government has been supportive of the sector’s expressed desire to achieve minimum qualifications for all personal care workers. As in many countries, the industry has had difficulties in recruiting and retaining appropriately educated and skilled staff, for a variety of reasons: the low status accorded nurses and long-term care workers; poor working conditions, particularly with respect to occupational health and safety; wage disparities with the acute care sector; and limited opportunities for professional development and career advancement. To help with these issues, the Australian Government’s 2002-2003 budget commits $AUD47.5 million over four years to encourage more people from rural and regional areas of Australia to enter or re-enter long-term care nursing and to support the education and training of workers in smaller homes.

Conclusion
Dr. Davies concluded by noting that there are significant challenges facing long-term care delivery in Australia, driven primarily by demographic issues and the desire of individuals to receive services in their homes. Improvements have been made through a series of incremental reforms. Two major reviews are underway that will provide insights into how to continue these reforms in the future, so that the Australian Government can continue to provide high-quality, affordable long-term care to those who need it today and in the future.

The New Zealand Experience
The Honorable Annette King, Minister of Health of New Zealand, reviewed her country’s experience with respect to long-term care.

Background on Demographic Trends
She began by reviewing some demographic trends. By international standards, New Zealand continues to have a small and comparatively young population. Approximately 477,000 individuals, or just under 12 percent of New Zealanders, are currently age 65 or older, with about 1.3 percent age 85 or older. But like the rest of the world, New Zealand’s population is aging. While the pace of change will be quite slow over this decade (with the proportion of people age 65 and older increasing from 11.9 to 13.6 percent by 2011), it will pick up considerably after that. Between
2011 and 2021, the proportion of older people will increase from 13.6 to 17.6 percent, and it will reach 24.8 percent by 2041 and 25.3 percent by 2051. Aging is occurring in most, if not all, ethnic communities in New Zealand.

The New Zealand Long-Term Care System
Health and social care in New Zealand is funded predominantly through taxation, with a small private insurance market for health care.

Funding and administration:
Prior to 1994 long-term community care and rest home care for older people was funded through the Social Welfare benefit system, while geriatric hospital care was funded through public health funds. In 1994 responsibility for funding all long-term care for older people and younger people with disabilities was consolidated into a newly established Disability Support Services funding stream within the health budget. This funding stream was originally administered by four Regional Health Authorities. This arrangement was then changed so that funding and administration came from a single national funder. In October 2003, funding for disability support services for older people was devolved to 21 District Health Boards, which are largely elected boards charged with the responsibility of maintaining and improving the health of the population in their districts. These responsibilities include funding primary health care, community health services, hospital-based services, and long-term support for older people (all people age 65 and over, and those age 50 to 64 with complex health needs associated with old age). The hope is that these District Health Boards will be able to take the funds they receive for both health and disability support services to develop a continuum of care for the elderly, with incentives to focus on health promotion, disease prevention, and early intervention. This initiative is closely linked to the establishment of Primary Health Organizations (PHOs), which are groups of primary health professionals that work together to provide more accessible and affordable primary health care. Growth in this program has been significant. The first two PHOs were established in July 2002, and by October 2003, there were 53 in the country, collectively covering more than half of New Zealanders. More than a quarter of the population is receiving less expensive health care as a result. In July 2004, all individuals over the age of 65 will be enrolled in this program.

Residential care: People age 65 and over who need long-term residential care can apply for a subsidy to cover all or part of the costs of such care. Access to a
subsidy is means-tested based on income and assets; individuals are expected to use their resources first before they become eligible for a subsidy. Most residential care is provided in the private sector in partnership with the government. Quality of care is monitored in part through the Health and Disability Sector Standards, which were updated in 2001 under the Health and Disability Services (Safety) Act and should be fully implemented in all hospital and residential care facilities by 2004. These standards require residential care providers to establish safe practices and continuous quality improvement systems. Facilities are audited against the standards and receive certification when they meet required levels of service.

Home care: The majority of older people still live in their own homes. For example, almost three-quarters (72 percent) of those age 85 and over live at home, 15 percent of whom live without any assistance. For those who need assistance, the 1994 New Zealand Framework for Disability Support Services established a process to access such services. Under this policy, needs assessment and service coordination agencies were established to undertake holistic assessments of individual needs, and to work with these individuals to develop a support package to meet these needs. A key aim of this reform was to move from inflexible, nationally specified “entitlements” to a more flexible system based on individual need. These agencies are responsible for managing the transition from the home to residential care, and have succeeded in reducing entry rates to residential care to a rate below that of the population growth in older age groups. At the same time the number of people receiving community support services has increased. That said, despite this progress, the bulk of Disability Support Services funding (about 63 percent) still goes to residential care, compared to about 14 percent to support people at home. But those who enter residential care today are quite ill, and many have only a short time to live. For example, 22 percent of people entering residential care during 2000 died within three months, and 40 percent died within a year. These statistics underscore the success that New Zealand has had in helping people retain their independence.

Provision of long-term care: When funding for long-term care was originally consolidated into Disability Support Services, most community and residential care was provided by either public or not-for-profit (usually religious and welfare) organizations. During the 1990s demand for residential care increased significantly, creating incentives for
private for-profit organizations to enter the market with large facilities and modern amenities. These organizations also diversified into retirement villages that provide a range of accommodation on a single site, from independent living units to full hospital care.

**Underlying Philosophy of the System**

New Zealand has adopted the World Health Organization concept of “active aging” in developing policies related to older people. The concept underpins the New Zealand Positive Ageing Strategy, published in 2001, which provides a framework within which all policies with implications for older people are developed. The strategy sets out ten goals in the areas of income, health, housing, transport, aging in place, cultural diversity, rural areas, attitudes, employment, and opportunities. Action plans are developed each year across 30 government agencies to achieve the goals. Regular reports to the government track progress and highlight emerging issues.

The health and long-term care component of the strategy — focuses on supporting people to live at home for as long as it is safe and desirable to do so. To that end, the government is supporting a range of not-for-profit community initiatives and is funding an evaluation of three pilot schemes providing ongoing support to vulnerable older people living in their homes. Two of the schemes also provide intensive rehabilitation and home support from a workforce that is trained to work alongside the person, not to take over the person’s tasks. This approach encourages individuals to continue doing daily tasks as a form of exercise. Examples of projects under this initiative are listed below.

- In New Zealand’s South Island, the Elder Care Canterbury program involves a series of projects designed to integrate and improve health services for older people. These include an initiative called Stay on Your Feet Canterbury, which aims to raise awareness of the risks and consequences of falls among the elderly. A home-based, individualized exercise program has been set up, with volunteers to support participants during the first six months.

- The Elder Friendly project has developed a set of guidelines for use by staff in hospital emergency departments.

- Ageing is Living is a national program that serves as an education and training resource for people aged 40 and above. While this may seem to be a relatively young age to start, the program’s quizzes, activities, and strategies for self- and group-learning help change

In New Zealand, 72 percent of those age 85 and over live at home, 15 percent of whom live without any assistance.
people's attitudes about aging, thus encouraging them to plan ahead. The program is publicly funded but run by a non-governmental organization. It is designed to promote successful aging and prevent depression among older people.

- The Waikato Agewise Strategy promotes holistic-based wellness in an effort to draw together and coordinate health and other relevant services to enable older people to remain healthy and active in their communities.

**Issue of the Future: The Long-Term Care Workforce**

Ms. King closed her presentation by outlining the issue of workforce shortages, a problem New Zealand shares with many other nations. New Zealand faces workforce shortages across a range of health settings, including in long-term care, where there is a general shortage of registered nurses. Nurses and caregivers in this sector have traditionally been paid less than in other sectors. In addition, there are limited postgraduate training programs. As a result, relatively few young individuals are entering the profession, and the average age of nurses is rising significantly. To address this issue, training programs for caregivers, which in the past have developed in ad hoc ways, are now becoming more consistent across the nation. In addition, work is underway to develop and regulate minimum staffing levels in residential care facilities.

But despite these efforts, the issue of workforce shortages will remain a challenge in the years ahead, especially as the population of New Zealand continues to age and the demand for services continues to increase. Just as New Zealand's experiences may provide valuable lessons for others, Ms. King believes that the experiences of other nations can prove quite useful in helping to address the challenges facing her country's long-term care system as well.

**Conclusion and Wrap-Up**

Ms. LeaMond closed the proceedings by thanking the participants and emphasizing the tremendous value to be gained by sharing ideas and examining the experiences of others. This sharing of “best practices” and innovative ideas can be extremely helpful to policymakers in the U.S. and other nations as they struggle to find strategies for addressing the tremendous challenges involved in providing timely, affordable, efficient, and high-quality long-term care services to everyone who needs them.
Biographies

John Creighton Campbell  
Professor of Political Science,  
University of Michigan  

John Creighton Campbell has been teaching political science at the University of Michigan for thirty years. He specializes in public policy, process and substance, especially social policy, in Japan. His books include *Contemporary Japanese Budget Politics* (California, 1977), *How Policies Change: The Japanese Government and the Aging Society* (Princeton, 1992), and (with Naoki Ikegami) *The Art of Balance in Health Policy: Maintaining Japan's Low-Cost, Egalitarian System* (Cambridge, 1998). These books also appeared in Japanese. He has also written on organizations, U.S.-Japan relations, the automotive industry, and electoral behavior, and is directing a project that compares changing political attitudes in Japan and the U.S. through analysis of survey data.

Mr. Campbell was educated at Columbia (B.A. 1965, Ph.D. 1973). He has held a variety of administrative posts, including Secretary-Treasurer of the Association for Asian Studies (1994-2000), and acting director of the Kyoto Center for Japanese Studies (2000-2001). He has received various fellowships (Fulbright, Woodrow Wilson Center, Japan Foundation, Abe) and has been a visiting professor at Keio, Doshisha and Hebrew Universities.

Philip Davies  
Deputy Secretary, Department of Health and Ageing, Australia  

Philip Davies joined the Australian Department of Health and Ageing as a Deputy Secretary in August 2002. He is a member of the Department’s Executive, and has specific responsibility for the Acute Care, Primary Care, Health Services Improvement and Medical and Pharmaceutical Services Divisions. He brings to the role almost 25 years’ international experience in health care policy and management.

After graduating in mathematics, Mr. Davies spent five years working with the British Department of Health and Social Security in London followed by 14 years as a specialist health care management consultant with Coopers and Lybrand in the U.K. and New Zealand.

In 1997 Mr. Davies joined the New Zealand Ministry of Health as a Deputy Director-General. He left at the end of 2000 to spend 18 months as a Senior Health Economist with the World Health Organization in Geneva before taking up his current position.

Joanne Disch  
AARP Board Member & Professor and Director of the Katharine J. Densford International Center for Nursing Leadership  

Joanne Disch, Ph.D., R.N., F.A.A.N., of Minneapolis, Minnesota, is a member of the AARP Board of Directors and a professor and director of the

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Katharine J. Densford International Center for Nursing Leadership, and the Katherine R. and C. Walter Lillehei Chair in Nursing Leadership at the University of Minnesota School of Nursing.

Dr. Disch has been an administrator of health care facilities, most recently senior associate director/director of nursing at the University of Minnesota Hospital and Clinic (UMHC), and vice president of patient/family services at Fairview-University Medical Center. In these positions, she successfully directed a $45 million cost reduction initiative and coordinated the clinical integration of patient care services following a merger between UMHC and Fairview Health Systems.

In the volunteer capacity, Dr. Disch has been president of the American Association of Critical-Care Nurses (AACN), a 65,000 member nursing specialty organization; president of the AACN Certification Board; chairperson of the American Nurses’ Association’s Committee on Nursing Practice Standards and Guidelines; and chairperson of the University Healthcare Consortium’s Council of Chief Nurse Executives. Currently, she serves on several editorial boards, and is on the Board of Directors for the American Academy of Nursing.

Jeremy Hurst
Head of the Health Policy Unit, Organization for Economic Cooperation and Development

Jeremy Hurst has been head of the Health Policy Unit at the Organization for Economic Cooperation and Development (OECD) since 1999. The Health Policy Unit plays a leading role in the OECD’s Health Project, the main theme of which is performance measurement and performance improvement in OECD health systems. The Unit also plays a part in maintaining and improving OECD’s Health Data files.

A graduate of the London School of Economics, Hurst joined the U.K. Department of Health in 1971 as economic adviser, later becoming the senior economic adviser to the National Health Service Executive, with responsibility for a wide range of economic questions relating to the management of the National Health Service in England.

During his period at the Department of Health, he was sent on a Fellowship to the U.S. and Canada in 1980/81 to compare their methods of financing and delivering health services with those of the U.K. He spent 1990 on secondment to the OECD and prepared a report entitled The Reform of Health Care: a Comparative Analysis of Seven OECD Countries.

Hurst has also served as a lecturer in economics at the University of Durham and has published various comparative studies on health care systems and their performance.

The Honourable Annette King
Minister of Health and Food Safety, New Zealand

Annette King has been New Zealand's Minister of Health and Food Safety since 1999. From 1999-2002 she also held the position of Minister of Racing.

Ms. King was first elected as the MP for Horowhenua in 1984 and was appointed as the Under-Secretary to Ministers of Social Welfare, Tourism,
Employment and Youth Affairs in 1987.

Ms. King was the Minister of Employment, Immigration and Minister of Youth Affairs from 1989-1990. During this period, she also had a special role as Minister assisting the Prime Minister as a liaison between the Cabinet and Caucus. After losing her seat in 1990, Ms. King was appointed as Chief Executive for the Palmerston North Enterprise Board. She held this position until her re-election as Labour Party MP for Miramar in 1993.

Ms. King received her B.A. from the University of Waikato and also holds a post graduate degree in Dental Nursing.

Franz Knieps
Director General in the Federal Ministry for Health and Social Security, Germany

Mr. Knieps holds the position of Director General in Germany’s Federal Ministry for Health and Social Security, where he is responsible for public health care, health insurance, and long-term care insurance. He was previously the Health Policy Director of the Federal Association of Local Sickness Funds from 1991-2002. Mr. Knieps helped establish social insurance systems as a Senior Policy Adviser to the East German Government and Social Security Organization of the former GDR in 1990.

Following his studies in law, political science and German literature at the Universities of Bonn and Freiburg, Mr. Knieps worked as a Policy Adviser for the Federal Ministry of Labour, Health, and Social Security. He made important contributions to health care reform in the late 1980s, both as a health insurance representative on the Federal Labour Ministry’s Commission and as a Policy Adviser to the Parliamentary Commission on Health Care Reform.

Since 1990, Mr. Knieps has also been a consultant to the World Health Organization, the European Commission, as well as governments in Eastern Europe and Turkey.

Nancy A. LeaMond
Director of International Affairs, AARP

Nancy LeaMond serves as Director of International Affairs at AARP, focusing on the policy issues of the age 50 and over population worldwide through cooperation with like minded international organizations and governments.

Prior to joining AARP in late 2001, Ms. LeaMond served as Chief of Staff to U.S. Trade Representative Charlene Barshefsky. At USTR, Ms. LeaMond coordinated public affairs activities around the enactment of major trade agreements with Jordan and China, as well as the 1999 negotiations of the World Trade Organization.

During President Clinton’s first term, she served as the Assistant U.S. Trade Representative for Congressional Affairs, and advised then Commerce Secretary Mickey Kantor and William Daley on legislative, policy and management issues.

Ms. LeaMond served as President of the Congressional Economic Leadership Institute, a non-profit, non-partisan public policy group, and as Chief of Staff to U.S. Congresswoman Mary Rose Oakar, managing activities of the Committees on Banking and Finance, Civil Service, and Aging.
She also served in the U.S. Departments of Commerce, Education, and the then Department of Health, Education and Welfare.

Ms. LeaMond holds a bachelor’s degree in Sociology and Urban Studies from Smith College and a Master’s degree in City Planning and Public Policy from Harvard University’s J.F. Kennedy School of Government. She currently is a board member of the International Association of Homes and Services for the Ageing.

**William D. Novelli**
Executive Director and CEO, AARP

Bill Novelli is Executive Director and CEO of AARP, a membership organization of over 35 million people age 50 and older, half of whom remain actively employed. He joined AARP in January 2000 as Associate Executive Director and became Executive Director in June 2001.

Prior to joining AARP, Mr. Novelli was President of the Campaign for Tobacco-Free Kids and Executive Vice President of CARE, the world’s largest private relief and development organization. Mr. Novelli co-founded and was president of Porter Novelli, now one of the world’s largest public relations agencies and part of the Omnicom Group, an international marketing communications corporation. Porter Novelli was founded to apply marketing to social and health issues, and grew into an international marketing/public relations agency with corporate, not-for-profit and government clients. He retired from the firm in 1990 to pursue a second career in public service. In 1999, he was named one of the 100 most influential public relations professionals of the 20th century by the industry’s leading publication.

Mr. Novelli is a recognized leader in the international emergence of social marketing. He holds a B.A. from the University of Pennsylvania and an M.A. from Penn’s Annenberg School for Communication, and pursued doctoral studies at New York University. He taught marketing management for 10 years in the University of Maryland’s M.B.A. program and also taught health communications there. He has lectured at many other institutions. He has written extensively on marketing management, marketing communications, and social marketing. He also serves on a number of boards and advisory committees.

**John Rother**
Director of Policy and Strategy, AARP

John Rother is the Director of Policy and Strategy for AARP. He is responsible for the federal and state public policies of the Association, for international initiatives, and for formulating AARP’s overall strategic direction. He is an authority on Medicare, managed care, long-term care, Social Security, pensions and the challenges facing the boomer generation.

Prior to coming to AARP in 1984, Mr. Rother served eight years in the U.S. Senate as Special Counsel for Labor and Health to former Senator Jacob Javits (R-NY), then as Staff Director and Chief Counsel for the Special Committee on Aging under its Chairman, Senator John Heinz (R-PA).

He serves on several boards and commissions, including Generations United, the Health Care Quality Forum, the American Board of Internal Medicine Foundation, National Academy on Aging, Civic Ventures, and Citizens for Long Term Care.
He is a frequently quoted in the news, and regularly presents at conferences and congressional briefings. Throughout 1996, Mr. Rother was on special sabbatical assignment to study the consumer implications of the managed care revolution and the economic challenges facing the boomer generation.

John Rother is an honors graduate of Oberlin College and the University of Pennsylvania Law School.

P.J. van de Kasteele
Deputy Director, Department of Residential and Domiciliary Care and Seniors’ Policy, Ministry of Health, Welfare and Sports, The Netherlands

Mr. van de Kasteele is the Deputy Director for Residential and Domiciliary Care and Seniors’ Policy in the Ministry of Health, Welfare and Sports in the Netherlands. In his current position he is responsible for the financing of long-term care for the elderly as well as the building of nursing and residential homes.

In 1982, following his studies in economics at Erasmus University in Rotterdam, Mr. van de Kasteele began his career at the Ministry, where he was in charge of the section responsible for the financing of social health insurance schemes.

As head of the Social Insurance Department, Mr. van de Kasteele focused on Dutch healthcare reform plans from 1987-1996. He was subsequently the Deputy Director for Elderly Policies from 1996-2000, where he was responsible for residential homes for the elderly.

Joshua M. Wiener
RTI Fellow and Program Director for Aging, Disability, and Long-Term Care, RTI International

Joshua M. Wiener, Ph.D., is a Fellow and Program Director for Aging, Disability and Long-Term Care at RTI International. He is the author or editor of eight books and over 100 articles on health care for older people, long-term care, Medicaid, health reform, health care rationing, and maternal and child health.

Prior to coming to RTI International, Dr. Wiener did policy analysis and research for the Urban Institute, the Brookings Institution, the Health Care Financing Administration, the Massachusetts Department of Public Health, the Congressional Budget Office, the New York State Moreland Act Commission on Nursing Homes and Residential Facilities, and the New York City Department of Health.

Dr. Wiener received his B.A. from the University of Chicago and his Ph.D. from Harvard University.